*** PLEASE READ INSTRUCTIONS***

1. **REPORT BY EMPLOYER OF LEAVE STATUS FOR EMPLOYEE (Half sheet)**
   Form must be completed by your employer. Actual dates are to be recorded.

2. **PRELIMINARY STATEMENT OF DISABILITY-STD**

   SECTION TO BE COMPLETED BY EMPLOYEE
   Please complete necessary information relating to you. If injury or illness is unrelated to work, please complete designated section. For maternity benefits, it will be considered same as an illness. After completing your section, signature and date is REQUIRED before process begins. Please note - there is a seven (7) day waiting period for all non-occupational illnesses including maternity. Injury is considered the first day the injury occurs.
   IF WORK RELATED CONDITION, INQUIRE WITH THE WORKERS' COMPENSATION PROGRAM AT 928-871-6389

   SECTION TO BE COMPLETED BY EMPLOYER-(Do not complete)
   This section will be completed by the Employee Benefits Program once claim is received.

3. **ATTENDING PHYSICIAN'S STATEMENT OF ACCIDENT OR ILLESS**
   The entire page of the claim REQUIRES your physician to complete. If section incomplete, claim will be sent back to you for completion.

NOTE: For maternity claims, it is the responsibility of the employee to add a newborn to their policy at their discretion within thirty-one (31) days from the date of birth to allow coverage for the child from the date of birth. Otherwise, Open Enrollment Period would apply. Please contact our office to inquire.

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